Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Vfend

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Vfend.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Vfend (voriconazole)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is Vfend being prescribed by a hematologist, oncologist, or infectious disease specialist? Y N
2. Is Vfend being prescribed for a patient with invasive aspergillosis? [If no, then skip to question 10.] Y N
3. Is the patient immunocompromised or currently receiving immunosuppressive drugs? Y N

4. Does the patient have clinical manifestations (symptoms, signs, and radiological features) compatible with the diagnosis of invasive aspergillosis? Y N
   [Note: Supporting documentation must accompany request.]

5. Is this request for a continuation of therapy after an initial 30 days of therapy? Y N
   [If no, then skip to question 7.]

   Note: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.

6. Did the patient have a positive Platelia Aspergillus EIA test (detects circulating galactomannam antigen), biopsy, or culture? Y N

   Note: A copy of the original lab results is required. Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.
   [No further questions.]

7. Is this request for a continuation of therapy after an initial 90 days of therapy? Y N
   [If no, then skip to question 9.]

   Note: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.

8. Did the patient have a NEW positive Platelia Aspergillus EIA test (detects circulating galactomannam antigen), biopsy, or culture? Y N

   Note: New test results must accompany request for continuation of therapy after initial 90 days of therapy. Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.
   [No further questions.]

9. Did the patient have a positive Platelia Aspergillus EIA test (detects circulating galactomannam antigen), biopsy, or culture? Y N

   Note: A copy of the original lab results is required. Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.
   [No further questions.]

10. Is Vfend being prescribed for any of the following? Y N
    - Candidemia in a non-neutropenic patient
    - Candidiasis of the esophagus
    - Disseminated candidiasis of the skin and infections in the abdomen, kidney, bladder wall, and wounds
    - Serious infections due to Scedosporium apiospermum and Fusarium spp., including Fusarium solani

    Note: Please list site of infection.
    [If no, then skip to question 12.]

11. Has the patient's diagnosis been confirmed by one of the following tests? Y N
    - Thoracic CT
    - Culture(s)
    - Biopsy

    [Note: Please submit copy of test results.]
    [Skip to question 13.]

12. Has the patient received a transplant? Y N

    Note: Please list type and date of transplant.
    Note: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.

13. Does the patient have a documented treatment failure with one or more of the following in the past 90 days? Y N
    - Amphotericin B (Abelcet, Fungizone)
    - Fluconazole (Diflucan)
    - Ketoconazole (Nizoral)

    Note: Please specify drug name, reason for discontinuing, and dates of use. Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs are required for review.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date